

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-001915

255 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED JAN 28 1963

VS 300 Rev. 4/59	DATE AMENDED
1	
2 3668	
3	
4 1	
5 2	
6	
7 1	
8 0	
9 332X	
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12 66-0	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

Waldo S. Holt

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. (If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 60 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Lukes Hospital		d. STREET ADDRESS (If outside, give location) 4320 Oak	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth H. Volck		4. DATE OF DEATH Month Day Year January 14 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper-Veteran's Foreign Wars		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (City and state or country) Ohio		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME James Herron		13b. MOTHER'S MAIDEN NAME Clara Hickman	
14. NAME OF HUSBAND OR WIFE Howard A. Volck		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Hayes Wheeler, 2001 W. 83rd Terr. Leawood, Kansas	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 years 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 1956 to 1-14-63 and last saw her alive on 1-14-63 Death occurred at 11:55 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Fred L. Haas		22b. ADDRESS 4626 Kansas Parkway Kansas City, Mo.	
22c. DATE SIGNED 1-14-63		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-16-63	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	
23d. LOCATION (City, town, or county) Kansas City, Mo.		23e. DATE RECD. BY LOCAL REG. 1-15-63	
24. FUNERAL DIRECTOR Stine & McClure Kansas City, Missouri		25. REGISTER'S SIGNATURE Keith Long	

DEPT. OF HEALTH

1 To 3 -
Dec 1-1503
Charles Henry Kelly

STATEMENT BY LICENSED EMBALMER

5-85

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William M. Turner

Licensed Embalmer No. 4648
P. O. Address Lawrence City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.